

N. B.—Every item of information should be carefully supplied. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION is very important.

NOV 15 1937

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

36463

Do not use this space.

1. PLACE OF DEATH **Homer G Phillips Hospital** 791
 (a) County Registration District No.
 (b) Township Primary Registration District No.
 (c) City **St. Louis** (d) Street No. **2601** **N. Whittier** St. **10043**
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred **10** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Henry Frazier**
 (a) Residence, No. **527 Ohio** St. **22**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **Dol.** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Maggie Frazier**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Nov. 10th, 1886**

7. AGE YEARS **50** MONTHS **11** DAYS **16** If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **nil**
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) **Warren County, Mississippi**
 (STATE OR COUNTRY)

13. NAME **Charlie Frazier**

14. BIRTHPLACE (CITY OR TOWN) **Mississippi**
 (STATE OR COUNTRY)

15. MAIDEN NAME **unknown**

16. BIRTHPLACE (CITY OR TOWN) **unknown**
 (STATE OR COUNTRY)

17. INFORMANT **Evelyn Hilliard**
 (ADDRESS) **2601 N Whittier**

18. BURIAL, CREMATION, OR REMOVAL
 PLACE **Father Dickson** DATE **October 29, 1937**

19. FUNERAL DIRECTOR **F. A. Green Undertaker**
 (ADDRESS) **2915 Franklin Avenue**

20. **OCT 29 1937** Local Registrar. **J. B. Bredeck**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct. 26**, 19**37**

22. I HEREBY CERTIFY, That I attended deceased from **Oct. 19**, 19**37**, to **Oct. 26**, 19**37**

I last saw him alive on **Oct. 26**, 19**37**. Death is said

to have occurred on the date stated above, at **4 a.** m.

The principal cause of death and related causes of importance were as follows:

Cerebral apoplexy

Date of onset **10/19/37**

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? **clinical** Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19.....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) **L. L. Lewis**, M. D.

(Address) **2601 N Whittier**

STATEMENT BY LICENSED EMBALMER

I, F. A. Green, Licensed Embalmer No. 2963
hereby certify that the body recorded on the reverse side of this certificate was embalmed by F. A. Green
L. E.
No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. 2963

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)